Mutual Dell in Provo Canyon

Location:

Built of: _____ in _____ 19

Built by: People of LDS

Owned by: Church of JC of LDS

Operated by: Church of Jesus Christ of Latterday Saints

Picture of Log Building

" " Swimming Pool

Story told by ~~Phyllis~~ Murdock VanWagoner:

Mutual Dell was across the river to the north of Spring Dell in lower Provo Canyon. When the Vineyard ward of west Provo sent their young ladies to ~~Mutual~~ Dell, Norma Sumsion Holdaway (Harold Holdaway's wife) was their supervisors - The girls would hike all over the area - up to Bridal Veil Falls down to Murdock Dam etc. Swimming Pool near Log Lodge

Ref - Tues 3- -89 interview
c Phyllis VanWagoner

HEALTH INSURANCE CLAIM FORM

Type or Print

RAILROAD EMPLOYEES AND THEIR DEPEND

INSURED BY THE TRAVELERS INSURANCE CO

___ ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☒ OTHER

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME *(first name, middle initial, last name)*

2. PATIENT'S DATE OF BIRTH

3. INSURED'S NAME *(First name, middle initial, last*

4. PATIENT'S ADDRESS *(Street, city, state, ZIP code)*

5. PATIENT'S SEX — MALE ☐ FEMALE

6. INSURED'S I.D. NO. OR MEDICARE NO. *(Include any*

7. PATIENT'S RELATIONSHIP TO INSURED — SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. INSURED'S GROUP NO. *(Or Group Name)*

9. OTHER HEALTH INSURANCE COVERAGE – ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER

10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT — YES ☐ NO ☐
B. AN AUTO ACCIDENT — YES ☐ NO ☐

11. INSURED'S ADDRESS *(Street, city, state, ZIP cod*

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below

SIGNED DATE

13. *I authorize payment of medical benefits to unde physician or supplier for service described bel*

SIGNED *(Insured or authorized person)*

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTO — YES ☐ NO ☐

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY — FROM THROUGH

DATES OF PARTIAL DISABILITY — FROM THROUGH

19. NAME OF REFERRING PHYSICIAN

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES — ADMITTED DISCHARGED

21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR — YES ☐ NO ☐ CHARGES:

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE

1.
2.
3.
4.

24. A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE IDENTIFY( ) *(Explain Unusual Services or Circumstances)*	D DIAGNOSIS CODE	E CHARGES	F

25. SIGNATURE OF PHYSICIAN OR SUPPLIER

SIGNED DATE

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) — YES ☐ NO ☐

27. TOTAL CHARGE

28. AMOUNT PAID

29. BAL

30. YOUR SOCIAL SECURITY NO.

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CO TELEPHONE NO.

32. YOUR PATIENT'S ACCOUNT NO.

33. YOUR EMPLOYER I.D. NO.

I.D. NO.

PLACE OF SERVICE CODES:
1 – (IH) – INPATIENT HOSPITAL
2 – (OH) – OUTPATIENT HOSPITAL
3 – (O) – DOCTOR'S OFFICE
4 – (H) – PATIENT'S HOME
5 – DAY CARE FACILITY (PSY)
6 – NIGHT CARE FACILITY (PSY)
7 – (NH) – NURSING HOME
8 – (SNF) – SKILLED NURSING FACILITY
9 – AMBULANCE
0 – (OL) – OTHER LOCATIONS
A – (IL) – INDEPENDENT LABORATORY
B – OTHER MEDICAL/SURGICAL FACILITY